Ettie Lee Youth and Family Services
Referral for TBS Services

Fax or email TBS Referral to: Thomas Leppold, LMFT #44263
Phone: (909) 620-2521 Cell: (626) 236-0954
Email: thomas_l@ettielee.org Fax: (909) 620-9793

Please fill out form listing as much information as possible regarding the client being referred for TBS Services including listing the behaviors / symptoms to be targeted by TBS Services, the frequencies of the behaviors / symptoms, when they occur and do not occur, onset and severity /intensity of behaviors / symptoms.
If needed use additional paper or write on back of form or email.
If the client is being referred from an agency outside of Ettie Lee, the following paperwork / forms are needed to open the client in TBS: LAC DMH Child / Adolescent Full Assessment, Payer Financial Information PFI), Authorization to disclose / release Protected Health Information (PHI), and copy of client's MediCal card. A copy of the client's current Treatment Plan is helpful but not required.

Date of Referral: ______________________

Demographic and Placement Information:

Name of Child:__________________________________ Male or Female_________

DOB: ____________________ Age: ___________ SS#: _____________________

Medi-cal #: ________________________________ County: _________________

MIS#_____________________________ Ethnicity:_____________________________

MH Services (Current Episode) Admit Date ___________________________________

Group/Foster Home Admit Date (Current Placement) ____________________________

Group/Foster Home Discharge Plan ☐ Reunification ☐ Emancipation

School:____ Grade: ____________

School Address:____

IEP Services: ☐Yes ☐ No
When does client attend school? ______ AM to _____PM
What time does client return home from school? PM____________
☐ School suspensions How many? _______ ☐ School expulsions How many? _______

Suicide Attempts/Ideation: ☐ Yes ☐ No Hospitalized for psychiatric reasons ☐ Yes ☐ No
List current or history of suicide attempts/ideation.

____

____

Gang History: ☐Yes ☐ No Name of Gang and Activities: ___________________________

Current Drug Use: ☐ Yes ☐ No (list drugs used and frequency)

____

History of Drug Use: ☐ Yes ☐ No (list drugs used and frequency

____

Current Medications (listing names of medication, dosages in milligrams and frequency
____

____

Referred by: ___________________________________ Phone #: _____________________

Referring Agency: _______________________________ Phone #: _____________________

Contact Person @ Agency: _______________________ Phone#: ______________________

Resides: Group/Foster Home/ Home:____

Address, City, Zip: ____

____Phone#_______________________

Placing Worker Name: ________________________________ Phone: ___________________

Address, City, Zip: ____

____

Ward of Court (Probation): ☐ Dependent of Court (DCFS): ☐ Dual: ☐

Estimated discharge or court date (If in Group Home/Foster Home): ___________________

If Resides with Bio/Legal Guardian:

Parent/Legal Guardian Name: ____

Relationship: ___________________________________

Address, City, Zip: ____

____

Phone #: _____________________________ Primary Language: ______________________

Speaks English?_________________

Reason for referral for TBS Services:

☐ To prevent placement in higher level of care
(RCL 12 or RCL14 placement or locked unit or Juvenile Hall / Camp for example)

☐ To prevent further psychiatric hospitalization
(Psychiatric hospitalization with in the past 24 months for same mental health problem)

☐ Client / youth previously received TBS while a member of the certified class
(Psychiatric hospitalization with in the past 24 months for same mental health problem)

☐ To ensure transition to lower level of care
(To return to foster parent or parent's home or to emancipate)

Behaviors which are to be the Focus of TBS Treatment Goal(s)

☐ **Verbal Aggression**

☐ Severe Arguments ☐ Threats ☐ Gang Talk ☐ Belittling or demeaning ☐ Cursing

☐ Other, Describe____

Behaviors Directed Toward:

☐ Peers ☐ Group Home Staff ☐ Foster Parents/Parents ☐ Siblings ☐ Teachers/School

Occurring in: ☐ Group Home ☐ School ☐ Foster Home ☐ Home ☐ Community

Times of Day Behaviors Occur: ____

Times of Day Behaviors do NOT Occur:__________________________________

Frequency: __________________________ Duration: _______________________

Triggers:____

☐ **Physical Aggression**

☐ Hitting ☐ Kicking ☐ Fighting ☐ Throwing Objects ☐ Biting ☐ Destroying Property

☐ Other, Describe: ____

Behaviors Directed Toward:

☐ Peers ☐ Group Home Staff ☐ Foster Parents/Parents ☐ Siblings ☐ Teachers/School

☐ Pets/Animals

Occurring in: ☐ Group Home ☐ School ☐ Foster Home ☐ Home ☐ Community

Times of Day Behaviors Occur: ____

Times of Day Behaviors do NOT Occur: ____

Frequency: _______________ Duration: _______________________

Triggers:____

☐ **High Risk/Self Injurious Behavior**

☐ Punching Walls ☐ Running into the streets ☐ Breaking Windows ☐ Running Away
☐ Non-suicidal Self Injury, e.g., Self Cutting, Burning, Head Banging, etc.:
Please Describe: ____
____
☐ Other, Describe: ____

Behaviors Directed Toward:
☐ Peers ☐ Group Home Staff ☐-Foster Parents/Parents ☐ Siblings ☐ Teachers/School
☐ Pets/Animals
Occurring in: ☐ Group Home ☐ School ☐ Foster Home ☐ Home ☐ Community

Times of Day Behaviors Occur: ____
Times of Day Behaviors do NOT Occur: ____________________________________
Frequency: ________________ Duration: ________________________
Triggers:____

Does the client's symptomology require that his Coach be of a specific sex?

Yes ☐ (if yes: Male ☐ Female☐) **No** ☐ (Please note TBS may not be able to meet this need)

For Each TBS Target Behavior Listed:

How often are the Behaviors that are the Focus of Treatment for TBS Services occurring? (List the number of times per day or week and duration the behavior(s) are occurring. Write a statement for each behavior which is to be targeted for TBS Services.

When do the Behaviors that are the Focus of Treatment for TBS Services occur? Are there places or times the Behavior does not occur? (List when and where the behaviors occurring).

How severe and intense are the Behaviors that are the Focus of Treatment for TBS Services and long do these behaviors last?(List when and where the behaviors occurring).

What are the client's strengths and interests?

Does client have family that is involved in his treatment? Please list name and relationship (If none write none.):____

Current Diagnosis:

Primary: ___________________________ Code: ___________

Secondary: _________________________ Code: ___________

Secondary:__________________________ Code: ___________

Mental Health Code:

☐ Primary support group ☐ Social environment ☐ Educational ☐ Occupational
☐ Housing ☐ Economic ☐ Access to health care ☐ Interaction with legal system
☐ Other psychosocial/environmental ☐ Inadequate information ☐ Other: _______________

Medical Code: (if any)

Primary: ____________________________________ Code: _____________
Secondary: __________________________________ Code: _____________